Improving health care encounters and communication with transgender patients

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Abstract

Background/objectives: Transgender persons represent a generally ill-served or underserved population. This marginalized group continues to experience considerable difficulty in obtaining culturally competent health care despite recommendations by professional organizations and introduction of antidiscrimination legislation. This review examines communication and procedural barriers to transgender health care and suggests practical steps to help ameliorate disparities and unequal treatment.

Methods: Publications addressing health disparities and communication and procedural barriers to health care of transgender persons were identified by a structured search of electronic databases. The most pertinent articles are reviewed and consolidated with the authors' collective experiences.

Results: To improve their interactions and communication with transgender persons, health care providers can take a variety of practical steps in several key areas: office environment, registration forms, initial interview and assessment, confidentiality, personnel training, awareness of and compliance with applicable antidiscrimination legislation, health insurance-related issues, and outreach and transgender health promotion.

Conclusions: Enhancing patient satisfaction through culturally competent health care, quality assurance, and patient feedback is critical to creating open lines of communication between practitioner and patient and fostering a favorable context for transgender patient care.

Keywords: Transgender, Cultural competency, Physician–patient relations, Affordable Care Act, Attitudes, Antidiscrimination laws

Introduction

Transgender individuals continue to experience considerable difficulty in obtaining culturally competent health care,[1–5] despite position statements by numerous professional organizations and anti-discrimination legislation in many U.S. cities and states.[6–8] The disparity in health care experienced by transgender individuals is well recognized and is slowly being characterized and addressed.[1,9–20] Indeed, improving the health, safety, and well-being of transgender individuals is a goal of Healthy People 2020[21] and the U.S. Department of Health and Human Services has implemented initiatives to improve the health and well-being of transgender communities.[22]

Health care providers, along with health educators and policy makers, play a pivotal role in ameliorating health disparities and unequal treatment.[23] Meeting the health care needs of the growing population of transgender people may require many practitioners to acquire new communications skills, knowledge, and attitudes as well as bolster their awareness and receptivity to the transgender population. Thus, an opportunity exists for health communicators to play an important role in improving patient–provider communication as part of an overall strategy to help redress health care inequities experienced by transgender persons.

This review offers health care providers who aspire to improve health care encounters and communication with transgender individuals an overview of the prevalence of transgenderism, the health care needs of transgender people, and the barriers transgender persons face in accessing health care. Finally, the article suggests practical steps health care practitioners can implement in

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their practices to improve health care delivery to transgender people.

Methodology

A structured search of the National Library of Medicine PubMed database was used as a starting point to develop a comprehensive review of health care disparities, and communication and procedural barriers to health care of transgender persons, as well as practical steps to overcome these deficiencies. Original research, review articles, and editorials (1995–2013) in the English language were identified by combining the search terms transgender or transsexual with health care, barriers, disparities, attitudes, cultural competency, physician–patient relationship, and health needs assessment.

Other secondary searches (for various subsections) were also performed utilizing the terms transgender or transsexual and epidemiology, prevalence, disease management, antidiscrimination law, Affordable Care Act, health insurance, Medicare, Medicaid, and health legislation. Additional references were identified by a Google search and by searching the reference lists of identified articles. Preference was given to the most recent articles, those that employed quantitative or qualitative assessment via health care provider surveys, patient surveys, or focus groups, and those that provided practical suggestions on improving health care encounters and communication with transgender patients.

Collectively, these various searches identified a total of 357 citations possibly relevant to the topic, of which, a total of 82 are included in this review. The selected bibliography was intended to address a broad range of key issues, but it is by no means exhaustive. There were several excellent articles worthy of inclusion but these were largely duplicative and were left out in the interests of space.

Financial implications of improving patient communication and satisfaction

Since October 2012, 30% of Medicare reimbursements to hospitals is determined by institutional performance on the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS).[24] This nationally distributed 32-item survey measures patient satisfaction with their treatment after discharge from a hospital, particularly with respect to courtesy and respect by nurses and doctors.[25] Additionally, the HCAHPS survey results are publically available on the HCAHPS website (http://www.hcahpsonline.org/home.aspx). These measures highlight the benefits of providing culturally competent care and improving communication with all patient populations, including transgender persons.

Prevalence of transgenderism

For many years, transsexualism (see Appendix for definitions) has been considered a relatively rare condition, ranging in prevalence from 1:2900 to 1:100 000 for males-to-females and 1:8300 to 1:400 000 for females-to-males depending on the study, epoch, and country.[26] Mathematical modeling techniques to refine and extend data analysis of past studies suggest a much greater prevalence of between 1:1000 to 1:2000, and potentially as high as ~1:500 for male-to-female transsexuals (individuals who have undergone gender-affirmation surgery).[27]

The prevalence of the much broader category of transgender people may be in the 1% range, comparable to the prevalence of blindness in U.S. adults (~0.8%) and epilepsy (~1% in individuals less than 20 years of age).[28,29] The Massachusetts Behavioral Risk Factor Surveillance System surveyed 28176 adults 18–64 years of age between 2007 and 2009 and found that approximately 131 (0.5%, 95% confidence interval 0.3%, 0.6%) identified as transgender.[30] Thus, health care providers spanning the continuum of clinical specialties will likely encounter transgender persons seeking transition-related or non-transition-related health care in their practices at some point.

Terminology

A plethora of factors contribute to the overall sexual construct of an individual (Fig. 1). Gender identity pertains to a person's intrinsic sense of being male, female, other gender, or both genders and may or may not align with their biological sex (i.e. sex chromosomes, sex hormones, internal reproductive structures, and external genitalia) and sex assigned at birth. Individuals with gender dysphoria may present with a variety of permutations of these individual factors.

Categorization of gender identity variance as a psychopathology or normal biologic variation and the decision to include gender dysphoria in the Diagnostic and Statistical Manual (DSM) 5th Edition in 2013 has been hotly debated in recent years (for a review of the issues, see Refs. 31–33). Whether renaming gender identity disorder to gender dysphoria will achieve the intended goal of

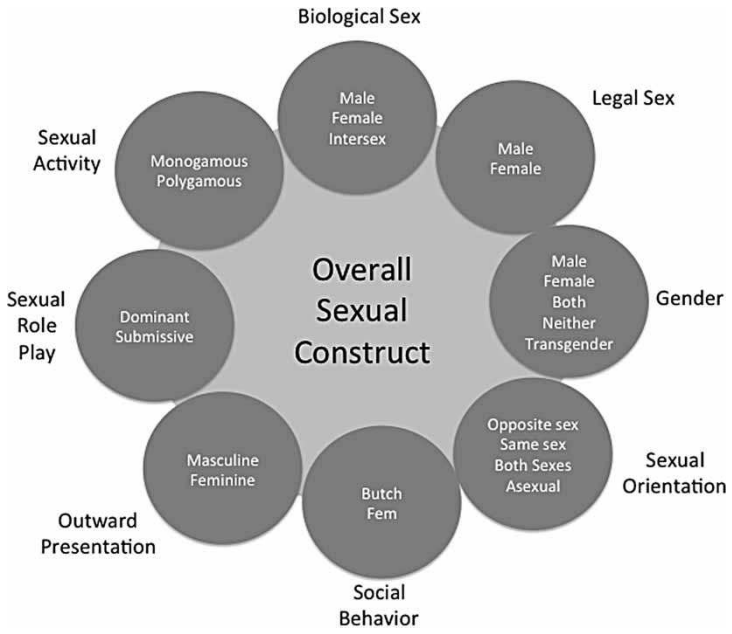

Figure 1 Summary of factors contributing to the overall sexual construct of an individual.

maintaining access to medical care while removing the stigma of a mental health diagnosis remains to be seen. It is important to note, however, that the decision-making process for inclusion in DSM 5 is not exclusively restricted to clinical issues pertaining to etiology, diagnosis, and management; it is also influenced by a broad range of psychosocial and political considerations as well as overarching patient needs (Table 1).

The inclusion or omission of the diagnosis of gender dysphoria in DSM 5 has far-reaching ramifications for numerous clinical and non-clinical groups and individuals. This includes medical, surgical, and mental health providers, legislators (political, civil rights, legal, disability), institutions with housing responsibilities (universities, hospitals, prisons), employers, transgender support networks and advocacy groups, educational institutions, and family members of people who are transgender.

Although gender dysphoria appears in DSM V, our perspective is that transgender identity is more of an ancient, persistent, and normal variation of human development rather than a mental pathology.[34] This is reflected anthropologically by variations of gender identity, expression, or role in non-Western cultures, such as the calalai (masculine female) of Indonesia, two-spirit people (aspects of

Table 1: Categorization of gender identity variance as a psychopathology or normal biologic variation.

Psychopathology	Normal variation
Represents psychiatric diagnosis that is primarily treated by surgical and medical interventions; limited effectiveness of reparative therapy in adults	Reflects an expression of human diversity not a mental/medical disorder
	Removes stigmatizing label
Stigmatizes and isolates from society	Aligns with anthropological evidence of gender identity, expression, or role in many non-western societies
Justifies medical, surgical, and mental health treatment of transgender persons to facilitate integrated transition	May lessen justification for mental health, medical, or surgical services and basis for medical insurance claims
Promotes development of transgender services and guides research into origins, consequences, and treatment options	Redirects attention on social forces that oppress gender non-conformity and thereby create distress/suffering
Provides clinical diagnostic underpinning for medical insurance claims	Reflects diversity within the transgender community regarding stages of transition
Provides foundation for employment and health care discrimination cases	Bolsters transgender patients legal standing in child custody disputes
Maintains economic incentives for many stakeholders and gate keepers	Results in patients paying out of pocket for all transition-related services

both genders) among Native Americans, and the hidras (neither man nor woman) of India.[35]

Disparities in health care among transgender persons

Transgender persons represent a generally ill-served or underserved population that frequently encounters health care providers who refuse to provide services or do so grudgingly and in a degrading manner.[1,3,4] To avoid stigma, emotional pain, and discrimination, transgender persons may feel unsafe to speak openly and honestly with health care providers about their gender identities.[1]

The social stigma encountered by transgender people creates a formidable barrier to their accessing health care and effectively communicating with providers.[36] These barriers may negatively impact health-seeking behaviors and are not without serious consequences (depression, suicide, and substance abuse).[37,38] Transgender patients, therefore, have to carefully consider two disparate scenarios: on the one hand, failure to disclose transgender status to a health care provider may potentially lead to inappropriate or unsatisfactory care; on the other hand, disclosure of this information makes transgender people potentially more susceptible to prejudice and, in some instances, refusal of health care.[1]

A recent study suggests that providers tend to approach medical encounters with transgender patients with ambivalence and uncertainty, perhaps, in part, because of limited training.[38] Many undergraduate medical education curricula pay little attention to appropriate medical care for transgender individuals.[39]

Several large surveys highlight the challenges transgender people face in receiving medical care. A nation-wide survey of 6450 transgender and gender non-conforming participants revealed that one in five had been refused medical care and roughly half reported having to teach their providers about transgender care.[40] Similar findings were reported in another national survey of 4916 lesbian, gay, bisexual, and transgender (LGBT) or HIV-positive individuals of which 700 identified themselves as transgender, gender-nonconforming, or two-spirit. The survey published in 2010 found that almost 27% were refused needed medical treatment and 70% had at least one experience of health care professionals who refused to touch them or employed excessive precautions, used harsh or abusive language, blamed them for their health status, were physically rough or abusive, or refused to treat them.[1] These findings are corroborated to varying degrees with the results of other smaller surveys of transgender people conducted in Philadelphia, Boston, and Virginia as well as results from community-based focus groups in Ontario, Canada.[2–4,41]

In major metropolitan areas such as Philadelphia, San Francisco, New York City, Chicago, and Virginia (primarily urban and suburban areas), approximately 60–81% of transgender individuals reported having (or seeing within previous six months) a doctor or primary care physician (Table 2).[4,41–44] Nevertheless, depending on the study, 23–49% of transgender individuals had no

Table 2: Summary of published studies evaluating experiences of transgender (TG) patients in accessing health care.

	Study					Range
	Clements-Nolle *et al.*[42]	Kenagy and Bostwick[44]	Kenagy[4]	Sanchez *et al.*[43]	Bradford *et al.*[41]	
Location	San Francisco	Chicago	Philadelphia	New York City	Virginia	
Sample size	515	111	182	101	350	101–515
TG Population	M-to-F F-to-M	M-to-F F-to-M	M-to-F F-to-M	M-to-F	M-to-F F-to-M	
Regular GP or seen GP <12 months	79%	72%	67%	81%	60%	60–81%
No health insurance	49%	35%	–	23%	29%	23–49%
Denied medical services or experienced health care discrimination because TG	–	12% (routine medical care); 23% (TG-related care)	26%	–	27%	12–27%
Access to TG knowledgeable provider as a barrier to care	–	–	–	32%	–	32%

health insurance, 12–27% had been denied medical services or experienced health care discrimination because they are transgender, and 32% reported difficulty accessing a provider knowledgeable about transgender health issues. Clearly more independent, peer-reviewed studies are needed to more adequately address the last two issues, and thereby provide a solid baseline against which the impact of health communications programs can be assessed.

Transgender individuals often have lower household incomes than their gender-conforming peers. The National Transgender Discrimination Survey revealed that approximately 15% of the 6450 transgender people surveyed had household incomes less than $10 000/year; this percentage is considerably higher than that in the general population (4%).[40] Poverty and joblessness impact the ability of transgender people to obtain private health insurance.[36] Further, private and public health care plans have historically specifically excluded treatments related to transgender status and do not cover gender-affirmation surgery.[36] However, this situation has changed considerably with introduction of the Affordable Care Act 2010 (see later). In addition to insurance coverage and/or financial means to pay for services, health care access for transgender people also involves identifying providers knowledgeable about transgender health issues and able to provide culturally competent care.

Health care needs of transgender persons

Transgender persons experience the same general life problems and require the same basic health needs (screening, prevention, treatment) as their non-transgender counterparts.[34,45] In addition, many also have clinical issues specifically related to, associated with, or exacerbated by their gender incongruence including (1) mental hygiene issues (depression, alcohol or substance abuse, anxiety, suicidal tendencies); (2) increased susceptibility for sexually transmitted diseases due to high-risk behavior; and (3) other medical conditions resulting from the iatrogenic effects of cross-sex hormone therapy.[34]

Despite the need for preventive and therapeutic medical care, many transgender persons often postpone a clinical consultation due to discrimination (28%) or economic reasons (48%).[40] It is not uncommon for transgender people to seek medical services only when they encounter a serious health care problem requiring emergency services. As a result, preventable illnesses go untreated, complications worsen, and costs for care correspondingly increase.[20]

Providers should be aware of a wide variety of issues of potential clinical relevance that may directly or indirectly impact the medical care of transgender patients (Table 3). Of course, no single provider will have the expertise to adequately address all of these issues and referral to an appropriate specialist is essential should any of these arise during a consultation.

Barriers to transgender health care and patient communication from the provider's perspective

Currently, few studies have comprehensively addressed the knowledge and attitudes of health care professionals toward transgender persons. A recent qualitative analysis of physicians providing health care for transgender persons in Ontario, Canada, uncovered multiple barriers to the medical care of transgender persons (Table 4).[11]

Another informative survey examined the barriers to optimal care between physicians and LGBT and questioning adolescent persons. This 2003 survey, which was conducted by Kitts at the Upstate Medical University in Syracuse, New York, involved a total of 184 residents and attending physicians in six different specialties.[10] While not focusing exclusively on transgender individuals, the survey did reveal that a minority of physicians (8.5%) regularly discussed gender identity while charting the sexual history of a sexually active adolescent.

Over the past half-century, attitudes of health care providers toward transgender persons appear to be trending in a positive direction. This assertion is evidenced by comparing physicians' attitudes in an early study conducted by Green *et al.*[47] in 1966 with those in more recent studies published by Franzini and Casinelli (1986),[16] and Willoughby *et al.* in 2010.[46]

Green *et al.* surveyed a total of 355 physicians (psychiatrists $N = 168$, urologists $N = 51$, gynecologists $N = 43$, and general practitioners $N = 93$) and found that between 80 and 86% (depending on specialty) believed that a transsexual requesting sex reassignment was severely neurotic.[47] When presented with a hypothetical typical case history of a male-to-female transsexual individual, only 3–9% would approve sex affirmation surgery (the threat of suicide only slightly changed this finding).

Not surprisingly, the percentage of respondents who would approve surgery progressively rose with the inclusion of increasingly stringent stipulations. For example, stipulating that the patient was not psychotic or severely ill mentally increased the percentage of physicians approving surgery from 6 to 19% for general practitioners, from 9 to 21% for

Table 3: Topics of potential clinical relevance when assessing or addressing the medical needs of transgender individuals.

- Hormone therapy
  - Testosterone, estrogen, progestin (illicit or prescribed)
  - Testosterone-blocking agents
  - Gonadotropin-releasing hormone analogues to delay puberty
- Gender-identity related issues
  - Feelings about being transgender
  - Family, cultural, religious conflicts
  - Issues and coping mechanisms related to pervasive societal stigma and membership in a marginalized population
  - Chronic stress
- Procedures undertaken to change body to match gender identity
  - Mastectomy, hysterectomy, phalloplasty
  - Penectomy, orchiectomy, neovagina formation
  - Facial feminizing surgery, unsafe silicone self-injections
- Safety
  - Physical, sexual, and emotional abuse
  - Experience of hate crimes
- Alcohol/drug use
  - Alcohol abuse and dependence
  - Abuse of 'party drugs' such as cocaine, crystal meth, ecstasy, ketamine, bath salts, synthetic marijuana (K-2), spice
- Cross-sex hormone side effects
  - Cardiovascular and cerebrovascular disease, thromboembolic disease
  - Liver damage, cholelithiasis
  - Type 2 diabetes
  - Blood lipids, lipoproteins, pancreatitis, laboratory test abnormalities
- Mental health issues
  - Depression, anxiety
  - Suicidal ideation, gestures and attempts
  - Self harm (especially in teenagers)
  - Decreased expectations related to relationship, educational and career success
- Safe sex
  - Hepatitis
  - HIV/AIDS and other sexually transmitted diseases
- Social issues
  - Support network (family, friends, etc.)
  - Connection with transgender community
  - Social isolation, work, housing, educational issues
  - Employment discrimination, income disparity

Table 4: Physicians' perceptions of barriers to health care of transgender persons.*

- Difficulty in identifying transgender-friendly physicians for specialist referrals
- Ethical considerations pertaining to transition-related medical care
- Knowledge deficits and lack of training regarding transgender-specific treatment
- Transgenderism considered a reversible psychological issue best treated with psychiatric intervention
- Pathologizing a patient's transgender status and confusing their condition with other psychiatric illnesses (e.g. transvestic fetishism, paraphilias)
- Limitations of the broader health care system in terms of recognizing and accommodating transgender persons into system segregated into a binary-sex designation
- General lack of interest in transgender health care
- Concern over potential regret of transgender persons after undergoing irreversible hormonal or surgical treatments and the potential legal liability
- Unrealistic expectations of transgender patients and difficulty in predicting realistic treatment outcomes

*Content extracted in part from Snelgrove JW, Jasudavisius AM, Rowe BW, Head EM, Bauer GR. 'Completely out-at-sea' with 'two-gender medicine': a qualitative analysis of physician-side barriers to providing health care for transgender patients. *BMC Health Services Research* 2012;12:110–113.

psychiatrists, and from 3 to 8% for surgeons. Nevertheless, only 25% of respondents thought affirmation surgery would likely improve the patient's mental health; 25% thought it would be definitely harmful (50% thought there was an equal chance of benefiting or harming the patient). Between 3 and 11% of physicians thought transsexual patients should be institutionalized (none believed the person should be imprisoned).

In the nationwide survey by Franzini and Casinelli (conducted in 1982, published in 1986), the authors surveyed general practitioners, urologists, obstetrician-gynecologists, psychiatrists, and clinical psychologists ($N = 202$) and, in part, replicated sections of the original Green questionnaire. The authors noted a favorable trend (greater social acceptance and willingness to recommend a surgical remedy as well as a less psychopathological view point) in attitudes relative to attitudinal data garnered almost two decades earlier in the 1966 study by Green *et al.*[47] While there was no difference in factual knowledge among the five groups of health care professionals evaluated, clinical psychologists tended to hold more liberal views compared with more conservative general practitioners.

Relative to the 1966 Green study, the Franzini and Casinelli survey showed a significant increase in the percentage of respondents who favored gender affirmation surgery for the hypothetical transsexual patient with the added requirement that the patient was not severely ill mentally or psychotic, as determined by a psychiatrist. Over the 16-year period from 1966 to 1982, the percentages of physicians favoring surgery for this patient increased from 19 to 38% ($P < 0.05$) for general practitioners, from 8 to 46% ($P < 0.001$) for surgeons, and from 21 to 48% ($P < 0.001$) for psychiatrists. There were no clinical psychologists in the Green study so this group could not be compared.

Closer review of the Franzini study revealed somewhat less encouraging attitudes. While 82% of the 202 respondents endorsed protection of civil rights and antidiscrimination legislation, a majority (61%) believed transsexuals would be better off relinquishing their desire for surgery and 54% believed that reassignment surgery would be deleterious to the patient's mental health. The majority (72%) of respondents gave an unfavorable response with respect to the advisability of providing sex reassignment surgery. Although no specific percentages were provided, the authors asserted that most health care respondents believed transsexuals would be undesirable as colleagues and most thought that close personal relationships with them could be difficult.

In the 2010 survey of mental health professionals or trainees ($N = 88$), Willoughby and colleagues utilized the genderism and transphobia scale to assess anti-trans sentiments and behaviors among 88 mental health professionals or trainees.[46] Overall, the survey found low levels of genderism, transphobia, and gender bashing among mental health professionals and trainees, a finding consistent with the more liberal views of clinical psychologists in the 1986 study. Approximately 35% of respondents reported that they had seen a transgender patient professionally and 40% noted they had personal contact with a transgender person. Roughly a third of the participants considered themselves competent in gender issues and treating a transgender person.

Not surprisingly, professionals or trainees with less knowledge about transgender persons tended to have higher anti-trans sentiments and behaviors whereas those who had attended a gender and sexuality class exhibited lower levels of anti-trans attitudes and behaviors. Education of mental health providers in trans-related issues may be an important component in favorably impacting the provider/transgender patient dynamic.

In the same article by Willoughby *et al.*, the authors combined the survey results of health professionals or trainees in the United States with results from three other independent surveys they conducted in parallel among college students taking introductory psychology classes in the Philippines ($N = 207$), undergraduate, and graduate college students in Quebec, Canada ($N = 279$), and adult men and women in the United States ($N = 138$). Using the combined survey populations (as discussed on page 269 of the Willoughby's article), the authors found that respondents intolerant of transgender people tended to be social conformists, heterosexual, religious fundamentalists, male, morally dogmatic, ego-defensive, homophobic, and lacking in self-esteem.

Practical steps to improve health care-related encounters and communication with transgender people

Health care providers can take a variety of steps to improve their interactions with transgender persons and foster an atmosphere of openness, more satisfying patient-provider communication, and optimal delivery of care and services.[37,48–50]

Three comprehensive articles are worthy of special note, and the interested reader may find these invaluable: one relates to best practices for

front-line staff with respect to affirmative care for transgender and gender non-conforming people (developed by National LGBT Health Education Center, and The Fenway Institute), a second relates to transgender-affirming hospital policies (joint recommendations by Lambda Legal, the New York City Bar, and the Human Rights Campaign Foundation), and the third provides guidance for general practitioners, other clinicians, and health professionals on the care of gender-variant people (developed by the National Health Service in the United Kingdom).[51–53]

Office environment

The waiting room can be transformed into a more transgender-welcoming environment with a few simple modifications. This might include, for example, providing pertinent reading materials and displaying posters or decals to indicate that the office is transgender friendly and may be considered a safe zone.

Access to restrooms by transgender persons can be a lightening rod for many non-transgender persons. If feasible, providers should consider designating a unisex or single-stall bathroom as an option. Many trans-friendly university campuses offer gender-neutral bathroom maps to accommodate transgender students. A smart phone application (TranSquat) may also be used to locate gender-neutral bathrooms in the United States, Canada, and Great Britain. However, if a unisex restroom is not feasible, try to allow patients to use whatever bathroom is congruent with gender identity.[54] For the interested reader, the issue of bathroom use by transgender people is extensively reviewed in a document entitled 'Peeing in Peace: A Resource Guide for Transgender Activists and Allies' developed by The Transgender Law Center.[55]

Registration forms, intake interview, and initial assessment

All clinic documentation and all reception, intake and assessment, and direct-care staff should endeavor to use the correct pronouns appropriate to the patient's self-proclaimed gender identity. Calling a person 'it,' 'he/she,' 'she–male,' or 'the tranny' is never appropriate in any setting. Team members should feel comfortable correcting pronoun usage among colleagues (if you hear something, say something).

In some circumstances, the patient's preferred name (i.e. the name that should be on the chart) may differ from a patient's legal name. Thus, a patient may wish to be referred to as a female with respect to office records and in their interactions with health care staff, but male with respect to billing and insurance forms.[49] Because of its central importance to the patient's transgender identity, the patient's preferred name should be used whenever possible, even though this may be challenging at first with respect to clinic records.[56] It is inappropriate to place the patient's preferred name or preferred pronoun in quotation marks.

To meet transgender patients' unique medical record needs, electronic medical record software should accommodate these types of demographics and other pertinent transition-related medical information.[57] The ability to accurately notate novel clinical situations (e.g. a trans man requiring a pelvic exam or prenatal services and a trans woman requiring a prostate exam or prostate-specific antigen testing) is critical. It is prudent, therefore, to include health care information technologists as part of an overall communication strategy to improve transgender health care.

If a member of staff is unsure how to refer to a patient, ask politely 'What pronoun would you prefer I use for you?' Amending intake forms to ask about a person's gender identity as well as their sex assigned at birth can be very helpful in this regard, although simply revising intake forms does not automatically translate into greater comfort with or understanding of transgender people by staff.[58] Some degree of training will be required. Ideally, the health care team should view transgender status as just another demographic or anthropometric descriptor along with age, height, weight, and race.

Amending the intake form and allowing for optional self-identification as a trans person (male-to-female or female-to-male), transgender, intersex, etc., circumvents the provider having to rely on a patient's self-disclosure in conversation. The inclusion of gender inclusive language on the intake form also indicates to the patient that the practice represents a gender-affirming setting. In addition, it avoids discomfort or embarrassment for both patient and provider during a subsequent physical exam when it becomes apparent that the person's anatomy is incongruous with the person's gender identity and expression. Patients should be allowed the option of not answering confidential questions on the intake form when they would prefer to discuss privately with the health care provider in the examination room.[50]

Providers should endeavor to take a medical history of a transgender person in nonjudgmental tone, and approach each patient with respect and empathy. A transgender patient's trust in a health care provider can be negatively impacted by

making assumptions based on stereotypes,[58] particularly with respect to an individual's sexual behavior or orientation. As far as practicable, health care providers should try to provide some context for particular questions and should simply apologize if they unintentionally offend a patient by asking particular questions or making certain assumptions.

Because many transgender people have experienced unfavorable encounters with health professionals in the past, they may be reluctant to out themselves with a new provider (unless circumstances compel them to do so) for fear of rejection, discrimination, or denial of care. Further, once in a practitioner's care, transgender people may be tempted to withhold personal information for similar reasons and this may negatively impact their well-being and standard of care.

Health care providers should therefore conduct a thorough sexual and gender identity interview with all patients. This assessment should be conducted as part of a history and physical, which also includes depression/mental health screening and substance use profiles. The interview should be conversational, professional, and non-judgmental. Some major points to consider for the interview are discussed below.

Begin by introducing the topic and explaining why this background information is pertinent and an important part of providing high quality treatment. 'Since a person's sexual activity and gender identity can impact many different areas of their medical and mental health care, I ask all of my clients/patients some general questions related to this area of their life. If you do not want to discuss a certain area at this time, feel free to tell me and I will move on'.

If the patient declines to participate in the interview, the provider should assure the patient of their willingness to discuss these issues in the future if they have concerns. It is important to recognize that, by introducing this topic as part of an initial evaluation, the practitioner has taken steps to reduce stigma and promote a positive health care encounter. If the patient agrees to participate in the interview, the clinician can proceed by asking a variety of questions related the patient's sexual history (Table 5).

For many transgender persons, physical exams (or even the act of undressing) can be especially embarrassing, distressing, and uncomfortable, particularly during procedures or examinations related to anatomic sites that differ from their gender identity. These types of exams may be less traumatic for transgender patients if the underlying rationale is clearly communicated or routine exams are postponed until a more robust patient–provider relationship has been established unless, of course, clinical judgment dictates immediate assessment.[49] Some trans patients may be uncomfortable using or hearing their practitioner use correct anatomical terms for their incongruent anatomy (e.g. a trans man referring to a vagina). The use of illustrations or models representing procedures or anatomical sites may be especially helpful in this regard.[59]

Applicable prevention and screening procedures should be undertaken according to the anatomy (e.g. for male-to-female, prostate and breast exam

Table 5: Suggested questions that health care providers should consider asking to comprehensively characterize a patient's sexual and gender identity history.*

- How do you identify your sexual orientation, gay/lesbian, straight, bisexual?
- Are you sexually active? Do you practice safe sex at all times?
- Are you monogamous or do you have multiple partners?
- Have you been tested for HIV and other sexually transmitted diseases? What were the results?
- Would you describe your gender as male, female, transgendered, other gendered?'
- If transgender or other gender
  - Do you have a preferred name that I can use?
  - Are your medical records and insurance under your preferred name?
  - Are you taking any medications or hormones at this time or in the past?
  - Have you had any gender affirming surgical procedures?
  - Do you have a supportive community and/or family?
- Do you ever feel that your sexual orientation or gender identity has a negative impact on your sense of self-esteem or could be related to feelings of depression, isolation, or thoughts of self-harm?
- Have you encountered discrimination or sexual or physical abuse related to your expressed gender or sexual orientation?
- Are there any questions you want to ask me about these issues or is there anything you want to share with me related to your sexual orientation or gender identity?

*These lines of questioning are authors' suggestions only and have not been formally evaluated for effectiveness.

and measurement of prostate serum antigen; for female-to-male patients, pelvic exam, Papanicolaou test, and screening for polycystic ovarian disease unless total abdominal hysterectomy and bilateral salpingo oophorectomy performed).[49] Note, however, that even after bilateral mastectomy, female-to-male patients may still develop breast cancer and appropriate screening should be routinely performed.[60] Although breast cancer in male-to-female patients receiving long-term estrogen therapy has not been extensively documented, several cases have been reported and breast cancer screening should be conducted in a manner similar to non-trans women.[61,62] More detailed, up-to-date recommendations on routine health care services for trans people may be found on the web site for the Center of Excellence for Transgender Health, University of California, San Francisco.[49]

When providing health care to transgender adolescents, practitioners should honor, respect, and support a child who identifies as transgender. Providers should certainly avoid dismissing or trying to change the child's gender identity under the assumption that this is just a phase. The practitioner should pay particular attention to the presence of depression, anxiety, self-injurious behavior, substance abuse, and suicidal ideation, and recognize that puberty (unless suppressed by a gonadotropin-releasing hormone analogue such as leuprolide acetate) may represent a major life crisis.[34]

Early intervention to attenuate the development of secondary sex characteristics, especially in trans girls, prevents anatomical changes that are challenging to reverse in adulthood and allows children (and parents) time to reflect on gender variance and, what if anything, they wish to do about it.[34,63] It is recommended that a transgender child consult with a mental health professional with expertise in transgender-related issues as appropriate. An overview of the clinical guidelines on the health care of transsexual, transgender, and gender-nonconforming children and adolescents is beyond the scope of this article but further details may be found in several reviews.[34,64]

Confidentiality

Confidentiality is an important component in creating open lines of communication between health care providers and transgender patients and is critical in fostering a trusted partnership. Health care providers should ensure all client information relating to gender identity is strictly confidential, as with any other Health Insurance Portability and Accountability Act-protected information.

Providers should also inform transgender patients of the types of information collected, how it is protected and shared with other health care providers or third parties for reimbursement purposes, and how will it be used to benefit them.[37] Providers should avoid volunteering transgender status to other staff, family members, or other patients without the patient's explicit permission.

Personnel training

While the overall attitude of the general public toward gender incongruent people is slowly trending toward greater awareness, acceptance, and understanding,[65] it is likely that health care staff may be aware of transgender people but have had little or no direct personal contact. Practitioners should consider providing training for their office staff to help them improve communication with transgender patients, to avoid personal biases and assumptions, to recognize and avoid transphobia (i.e. fear and disgust of trans persons), and to increase staff knowledge of and sensitivity toward transgender patients.

Emphasis should be placed on getting to know the patient as a person not as a medical condition and treating the patient as they would want to be treated. Transgender people should not be considered 'sick but different'.[66] This approach is not unique to transgender patients and applies equally to patients with other medical conditions such as cancer. Empathy and sensitivity training of staff would benefit a wide range of patients.

Transgender individuals are not clinical experiments or educational opportunities, and every effort should be made to avoid focusing on gender-related issues unrelated to the primary purpose for the office visit. To gauge how office staff performs with respect to courtesy, helpfulness, and professionalism, consider asking patients to complete a brief questionnaire and make adjustments to office policy and procedure accordingly.

Antidiscrimination legislation

Antidiscrimination laws protecting transgender or gender-nonconforming persons have been enacted in many cities and states (see Transgender Law and Policy Institute web page for a comprehensive listing[7]) as well as at the Federal level.[8] Staff should be fully acquainted and compliant with all applicable legislation relevant to their practice. In addition, it is prudent to conspicuously post the office policy and/or relevant state and city policies regarding discrimination and outline the complaint

procedure for violations. If a non-discrimination policy is not in place, one should be developed and reviewed during job interviews, new staff orientation, and ongoing training.

The National Center for Transgender Equality (NCTE) as well as the Transgender Law and Policy Institute offer comprehensive and up-to-date information on recent transgender health care-related legislation.[7,8] As noted by NCTE, the Affordable Care Act prohibits any health program or organization that receives funding or is administered by the Federal government from discriminating against a person because they are transgender or do not conform to gender stereotypes.[8,67] This includes (1) refusing to admit or provide services; (2) harassing or refusing to respond to harassment; (3) subjecting a patient to intrusive and medically unnecessary examinations; (4) requiring participation in 'conversion therapy'; and (5) refusing to provide counseling, medical advocacy, or referrals. Another critically important aspect of the Affordable Care Act is the emphasis on initiating cultural competency training for health care staff, particularly primary care providers.[68] The Office for Civil Rights of the Department of Health and Human Services will investigate any complaints of sex-based discrimination, as outlined under Section 1557 of the Affordable Care Act, which also encompasses discrimination on the basis of gender identity and sex stereotypical ideas of masculinity or femininity.[67]

Health insurance-related issues

While the American Medical Association 'opposes the denial of health insurance on the basis of sexual orientation or gender identity' (resolution H-180.980) and 'supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician' (resolution H-185.950),[69] health insurance discrimination against transgender persons has hitherto been commonplace.

Historically, most medical insurance policies have not covered any items or services connected with transition-related health care. Identifying a patient as transgender or transsexual to an insurance carrier would typically result in the routine denial coverage for a variety of procedures[49] and, in some cases, depended on how the provider charted and coded their care.[58] However, the provisions of the Affordable Care Act 2010 beginning 1 January 2014 (see below) go a long way in resolving the lack of insurance coverage for transgender individuals and other marginalized groups.

Wide-ranging positive changes are expected with implementation of the Affordable Care Act, thereby stopping health insurance companies from raising rates or denying coverage because of pre-existing conditions, which include a transgender medical history.[8] The Affordable Care Act also prevents insurance companies from imposing a lifetime limit on coverage.[70] Furthermore, state health insurance exchanges, which began on 1 January 2014, may not discriminate based on gender identity or sexual orientation and are required to provide coverage for ten essential health benefits.[70,71]

According to the coverage determination guide of the health insurance company insuring one of the authors (J.S.R.), standard plans cover only psychotherapy for gender identity disorder and associated co-morbid psychiatric diagnoses, continuous hormone therapy, and laboratory testing to monitor such hormone treatment. Other plans offered, however, also include genital surgery (e.g. hysterectomy, orchiectomy, penectomy, vaginoplasty, vaginectomy, clitoroplasty, labiaplasty, among other procedures) and surgery to change certain secondary sex characteristics (thyroid chondroplasty, mastectomy, augmentation mammoplasty), provided, of course, the patient meets specified eligibility criteria.

Billing personnel should be aware of issues directly impacting insurance claims for transgender patients, especially in light of the Affordable Care Act, and should apprise the patient prior to communicating with the insurance company or benefits coordinator.

A promising shift has also occurred at the state level with respect to ending discriminatory exclusions of health care that is deemed medically necessary for transgender patients. Legislators have issued bulletins clarifying existing laws in California (Insurance Gender Nondiscrimination Act) and Oregon (Oregon Equality Act) and require that insurance companies provide coverage for certain treatments deemed medically necessary if the companies cover the same procedures for non-transgender patients.[72,73] Similar bulletins have been issued by legislators in Vermont,[74] Colorado,[75] and the District of Columbia.[76] In addition, a number of major universities are now offering students trans-inclusive health benefits.

At this time, Medicare (medicare.gov; a federally funded health care program underwritten by two trust funds) and Medicaid (medicaid.gov; a state-federal partnership guided by federal policy but with state-to-state variations), both administered through the Centers for Medicare and Medicaid Services of the Health and Human Services Department, do not cover gender reassignment surgery on the basis of the National Coverage

Determination (NCD).[77] The NCD, which has been in effect for over 30 years, states that transsexual surgery is not covered on the grounds that the procedure is considered experimental 'because of the lack of well controlled, long term studies of the safety and effectiveness of the surgical procedures and attendant therapies' and 'a high rate of serious complications for these surgical procedures'.[77]

Following the filing of an administrative challenge by national LGBT groups and a collaborating attorney, the Appeals Board of the U.S. Department of Health and Human Services issued a ruling (2 December 2013) on the challenge, which claims the clinical evidence is not complete or adequate to support the validity of the NCD[78–80] As a result of this ruling, the appeals proceedings now move on to discovery and taking of evidence, and ultimately this process will address whether the current ban on gender-affirmation surgery will continue.

Outreach and transgender health promotion

Establishing a network of colleagues or agencies with experience providing services to transgender persons and their families specifically or LGBT persons in general, will be invaluable for advice and referrals.

One way to show interest in welcoming transgender patients to a clinical practice is to advertise in LGBT and mainstream media, emphasizing the level and quality of health services and indicating that services are delivered without discrimination based on gender identity.[50] In addition, health care providers may consider speaking at local or national LGBT organizations and conferences.

Conclusions

Although many challenges remain in optimizing health care for transgender persons, health professionals can enhance patient communication and improve patients' subjective assessment of health delivery by modest changes.[81] However, it is important to note that politeness toward transgender persons *per se* does not translate into cultural competency in the provision of health care services.[45] Enhancing patient satisfaction through culturally competent health care, quality assurance, and patient feedback is critical to fostering a beneficial partnership between providers and transgender patients and in creating open lines of communication. Creating an atmosphere of openness is especially important with respect to transgender youth because this group can be very isolated and closeted.[48]

Providing culturally competent care to transgender persons also has financial implications since 30% of Medicare reimbursements to hospitals is determined by institutional performance on the HCAHPS Survey. Further, the Affordable Care Act has already provided some protection for transgender persons with respect to health insurance coverage and applies federal nondiscrimination policies at centers receiving federal health care funding.

Education of health care providers through continuing education programs and inclusion of transgender medicine and sensitivity training into health science teaching programs are also necessary to help reduce disparities in health care for transgender people. This article was developed to provide a succinct overview that could be used by practitioners as a starting point to help them improve communication with transgender patients as well as help them understand and overcome some of the barriers faced by transgender persons in the health care setting. It is hoped that the suggestions in this article will help to (1) promote equal access to and to optimally deliver health care services for transgender people; (2) foster a willingness of practitioners to embrace gender diversity, remove stigmatization of transgender people, and eradicate discrimination based on gender identity; (3) ensure that practitioners offer the best possible care to their entire patient community; and (4) promote awareness of transgender issues in the context of program development at medical schools and continuing medical education programs (CME). Inclusion of these issues in CME assures that health care personnel in the field remain current on changing approaches to care.

Appendix

Definition of terms used in this article (based in part on Coleman *et al.* and DSM 5).[34,82]

Transgender refers to a diverse group of individuals who cross or transcend culturally defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex assigned at birth.

Transsexual refers to individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

Trans man (female-to-male, F-to-M): Individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Trans woman (male-to-female, M-to-F): Individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Gender affirmation surgery (sex reassignment surgery): Surgery performed to change primary and/or secondary sex characteristics to affirm a person's gender identity.

Gender dysphoria (formerly gender identity disorder): Formal diagnosis presented in the Diagnostic Statistical Manual of Mental Disorders, 5th Edition (DSM-V). Individuals with a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her. Gender dysphoria is manifested by a strong desire to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender. The condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender identity: Intrinsic sense of being male, female, or alternative gender (e.g. boygirl, genderqueer).

Gender expression or role: Pertains to external attributes, behavior, appearance, dress, etc. that in a given epoch or culture are typically designated masculine or feminine.

Addendum

D Stroumsa recently published an excellent review on transgender US health care policy, law, and medical frameworks in Am J Public Health. 2014 Jan 16 (doi: 10.2105/AJPH.2013.301789).

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Bill Sinclair, LCSW, completed his Bachelor of Arts Degree at the University of Dallas and received his Master's Degree in Social Work (MSW) from New York University. Bill also earned a certification in Mental Health Evidence-based Practice from the New York State Office of Mental Health. Bill's clinical work has included ACT Team experience, Wellness-Self Management Group leader in an SRO setting, outpatient substance abuse treatment and most recently four years in a Manhattan psychiatric emergency department. Bill co-authored a paper on implementing Mental Health Evidenced-based Practices and has presented lectures on a variety of topics including interdisciplinary team dynamics, LGBTQ issues and bipolar disorder.